SHIGELLOSIS CASE INVESTIGATION - Page 1 of 5

Indiana State Department of Health
State Form 49694 (R2/1-05)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✓●
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name

First Name **MI** **Phone Number** - -

Number & Street Address

City **State** **ZIP Code** -

County **Date of Birth** / / **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Unknown

Sex:
- ○ Male
- ○ Female
- ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Occupation **Phone of Employer/School/Day Care** - -

Name of ○ **Employer** ○ **School** ○ **Day Care**

Address of Employer/School/Day Care

City **State** **ZIP Code** -

Section 2. Clinical Information

Symptoms:
- ○ Fever . *(degrees)*
- ○ Diarrhea
- ○ Blood in Stool
- ○ Abdominal Cramps
- ○ Nausea
- ○ Vomiting
- ○ Gas
- ○ Other, specify:

Date of Onset / /

Duration of Symptoms in Days

Date First Positive Specimen Collected / /

Source of Positive Specimen:
- ○ Stool
- ○ Blood
- ○ Urine
- ○ Other, specify:

If Known, Shigella Species:
○ sonnei ○ flexneri ○ boydii ○ dysenteriae ○ No Positive Culture

Group:

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Section 2. Clinical Information (continued)

Was Shigella strain resistant to any antibiotics?

○ Yes ○ No ○ Unknown

If Yes, antibiotic

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City **State** **ZIP Code** -

Physician/Hospital Phone - -

Was the patient hospitalized before or during infection?

○ Yes ○ No **If Yes, admission date:** / /

Discharge date: / /

Hospital:

Was the patient treated with antibiotics after onset? ○ Yes ○ No ○ Unknown

If Yes, antibiotic

Date started / / **Date ended** / /

Did patient die? ○ Yes ○ No

Section 3. Epidemiologic Information

List all commercial food establishments serving ready-to-eat food that the patient patronized during the 5 days prior to illness onset.

1. **Establishment Name**

Address

Foods Eaten (list) **Date** / /

2. **Establishment Name**

Address

Foods Eaten (list) **Date** / /

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Section 3. Epidemiologic Information (continued)

3. Establishment Name

Address

Foods Eaten (list) Date ___/___/___

List all group gatherings where food was served that the patient attended during the 5 days prior to illness onset.

1. Type of Gathering

Responsible Person

Phone Number ___-___-___ No. of Persons Date ___/___/___

2. Type of Gathering

Responsible Person

Phone Number ___-___-___ No. of Persons Date ___/___/___

Section 4. Risk Factors

Does the patient work in or attend a high-risk setting (e.g., food handling, child-care center, health care, institution)?

○ Yes ○ No ○ Unknown

If Yes, specify

Address

Phone number ___-___-___

Does anyone in the patient's household work in or attend a high-risk setting (e.g., food handling, child-care center, health care, institution)?

○ Yes ○ No ○ Unknown

If Yes, where

Address

Phone number ___-___-___

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Section 4. Risk Factors (continued)

During the 7 days prior to illness onset, did the patient:

Go swimming?

○ Yes ○ No ○ Unknown **If Yes, date:** ___/___/___

If pool, was it public or private?

○ Public ○ Private ○ Unknown

Type of water (pool, lake, river, water park, etc.)

Name of water body

Location of water body

Travel outside of Indiana? ○ Yes ○ No ○ Unknown

If Yes, where

Date of departure **Date of return**

Consume any raw fruits, raw vegetables, fresh herbs, or salads? ○ Yes ○ No ○ Unknown

If Yes, type of food

Where purchased

Date

List number of sexual partners during the last 7 days:

Males: **Females:** ○ **None** ○ **Unknown**

Did the patient have contact with anyone else who has recently had an illness characterized by diarrhea, fever, or abdominal pain or who has been diagnosed with Shigella?

○ Yes* ○ No ○ Unknown

If Yes, name

Relationship

Phone number **Date**

Question continued on next page. . . . .

**If more than one, please provide the above information for each on a separate sheet.*

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Section 4. Risk Factors (continued)

Question continued from previous page. . . . .

If Yes:

Does this other person work in or attend a high-risk setting (e.g., food handling, child-care center, health care, institution)?

○ Yes ○ No ○ Unknown

If Yes, specify

Address

Phone Number

Section 5. Comments/Follow-up

Comments:

Investigator Name

Agency

Phone Number **Date**